DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 04-002

2. STATE: South Carolina

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
April 1, 2004

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT:

a. FFY 2004 ($4,192)
b. FFY 2005 ($8,383)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

BASIC TEXT Page 71

Attachment 3.1-A, Limitation Supplement, Pages 6a.1, 6a.2, 6a.3 and 6a.4
Attachment 4.19-B, Pages 6, 6.1 and 6.2

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

BASIC TEXT Page 71
Attachment 3.1-A, Limitation Supplement, N/A

Attachment 4.19-B, Pages 6, 6.1 and 6.2

10. SUBJECT OF AMENDMENT:
To add disease management services to the South Carolina State Plan for Medical Assistance.

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Mr. Kerr was designed by the Governor to review and approve all State Plans.

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Robert M. Kerr

14. TITLE:
Director

15. DATE SUBMITTED:
March 19, 2004

16. RETURN TO:
South Carolina Department of Health and Human Services
Post Office Box 8206
Columbia, SC 29202-8206

[redacted]

OMB No. 0938-0193

Revision: HCFA-AT-84-2 (BERC)
01-84

State/Territory: South Carolina

Citation	4.23 Use of Contracts
42 CFR 434.4 48 FR 54013	The Medicaid agency has contracts of the type(s) listed in 42 CFR Part 434. All contracts meet the requirements of 42 CFR Part 434.
	☐ Not applicable. The State has no such contracts.
42 CFR Part 438	The Medicaid agency has contracts of the type(s) listed in 42 CFR Part 438. All contracts meet the requirements of 42 CFR Part 438. Risk contracts are entered into with any eligible and qualified MCOs. The risk contract is with (check all that apply):
	__X__ A Managed Care Organization that meets the definition of 1903(m) of the Act and 42 CFR 438.2
	____ A Prepaid Inpatient Health Plan that meets the definition of 42 CFR 438.2
	__X__ A Prepaid Ambulatory Health Plan that meets the definition of 42 CFR 438.2.
	____ Not applicable.

Components of Disease Management

All beneficiaries eligible to participate in the Disease Management Program will receive comparable services, based on their level of disease and co-morbid conditions. All beneficiaries will be assessed for their risk level and will receive follow-up education and disease management services appropriate for their risk level.

Disease Management Organizations (DMOs) will provide the services described below to beneficiaries eligible for the program. All FFS beneficiaries will receive the basic disease management interventions described in the first bullet. In addition to receiving the services described in the first bullet, FFS beneficiaries with Asthma, Diabetes and Hypertension will also receive the disease-specific interventions described in the second bullet.

- When necessary, assist in accessing appropriate primary and preventive medical care; care-coordination; referrals for specialty, social and ancillary services; and promotion of self-management. These activities will take place through use of a nurse consultation telephone line in which licensed registered nurses may initiate monitoring and follow-up calls to beneficiaries in the program, as well as to provide twenty-four (24) hour seven (7) days per week access to licensed registered nurse consultation for beneficiary calls about their treatment plan and self-management and management of medical crises. This nurse line will also operate as a means for identifying beneficiaries eligible for the disease management program and those who lack a primary medical home. Additionally field visits by a licensed registered nurse will be made to beneficiaries when appropriate.

- Initial health assessment by a licensed registered nurse and periodic follow-up of the ongoing health status of enrolled beneficiaries. The assessment process includes the development and implementation of an individual plan of care that addresses the beneficiaries' multiple health, behavioral and social needs, and that ensures continuity, quality and effectiveness of care in conjunction with the individual's health care provider (physician, physician's assistant, advanced practice registered nurses). In addition, the licensed registered nurse will: provide the beneficiary with health information related to patient self management skills, patient self-administration of medications, and crisis health care management; evaluate a beneficiary's health condition and make short-term medical recommendations subject to a provider's final approval; and assist the provider with implementation of the provider's care plan for the patient.

Choice of Providers

The state assures that there will be no restrictions on a beneficiary's freedom of choice of providers in violation of Section 1902(a)(23) of the Act. Eligible beneficiaries have free choice to receive or not receive disease management services through any DMO that meets the stated criteria below and may change case managers within their DMO at any time. Eligible beneficiaries also have free choice of the providers of other medical care under the Medicaid program.

Criteria for the Disease Management Organization (DMO)

a. All Disease Management case managers shall be licensed registered nurses and/or licensed social workers who meet the requirements of the contracted DMO.

b. DMOs that contract with the South Carolina Department of Health and Human Services to provide disease management services must meet the following conditions:

   1. Has a minimum of three years' experience providing disease management services;

   2. Has an evidenced-based healthcare practice guideline for each specific disease state being managed;

   3. Has an established collaborative healthcare practice model to include the State's current providers, community-based partners including, but not limited to, faith based organizations, school nursing programs and other support-service providers.

   4. Has patient self-care management educational materials and methods appropriate to each targeted disease population;

   5. Has internal quality assurance/improvement, outcomes measurement, evaluation and management systems;

   6. Provides access to a call center 24-hours-a-day, seven-days-per-week with licensed medical personnel who have training and/or are credentialed in the disease specific areas. All staff must be trained in at least the areas of establishing rapport, cultural sensitivity, and stages of change. The helpline must also be equipped with appropriate technology to accept calls from all members, ensuring program responsiveness and access to all services for people with limited English proficiency;

   7. Has the ability to guarantee program savings;

   8. Meets applicable federal and state laws and regulations governing the participation of providers and beneficiaries in the Medicaid program.

Comparability of Services

All beneficiaries eligible to participate in the Disease Management Program will receive comparable services, based on their level of disease and co-morbid conditions. All beneficiaries will be assessed for their risk level and will receive follow-up education and disease management services appropriate for their risk level.

Enrollment/Disenrollment Process

This Disease Management Program is a voluntary program. While all eligible beneficiaries will be automatically enrolled in the Disease Management Program; any beneficiary may disenroll through the following methods:

a. Beneficiaries may request disenrollment by calling their DMO. This process is referred to as ''opting out'' of the Disease Management Program.

b. DMOs may recommend disenrollment to the SCDHHS through an approved process.

c. SCDHHS may disenroll if:

- A beneficiary's eligibility ends;
- A beneficiary enrolls in a home and community-based waiver or hospice; or
- A beneficiary joins an agency-developed or other medical home model, such as a managed care organization.

Beneficiaries may also re-enroll in or " opt-in" the Disease Management Program by calling their DMO.

In accordance with federal interpretation, the disease management contracts are risk contracts. The method of payment has been developed using actuarially sound methodology per 42 CFR438.6 (c).

The State will pay the DMOs a per member per month capitated fee based on the total eligible population, and the prevalence of each disease within the total population.

The State expects a minimum, annual net cost savings of five percent (5%) in the overall medical costs of those beneficiaries with asthma, diabetes or hypertension. The guaranteed, annual net savings is defined as total savings minus SCDHHS expenditures on disease management services under the contract.

If the amount of guaranteed minimum, annual net savings is not achieved, the DMOs will pay the difference between the guaranteed minimum, annual net savings and the actual net savings to the SCDHHS. The DMOs will also be required to forfeit their fees.

13.d Rehabilitative Services

Reimbursement is made on the basis of an established fee schedule not to exceed the prevailing charges in the locality for comparable service under comparable circumstances. With public agencies the provider fee will not exceed the actual cost for the delivered service.

Rehabilitative Services for Primary Care Enhancement as defined in 3.1-A, pages 6c and 6d, paragraphs 13d. A, B, C and D may be provided by a physician or other licensed practitioner of the healing arts, or under the direction of a physician or other licensed practitioner of the healing arts as permitted by 42 CFR 440.130(d). The following services will be reimbursed by Medicaid as a rehabilitative service for Primary Care Enhancement:

(A) - Individual rehabilitative services for Primary Care Enhancement provided by a professional or a paraprofessional (unit of service - 15 minutes)
(B) - Group rehabilitative services for Primary Care Enhancement provided by a professional or a paraprofessional (unit of service - 15 minutes)
(C) - Assessment provided by a professional (unit of service - 15 minutes)

Medicaid reimbursement rates for rehabilitative services for Primary Care Enhancement will be established utilizing Medicare reasonable cost principles, as well as OMB Circular A-87 and other OMB circulars as may be appropriate. The rates will represent composite rates, in that professional and paraprofessional costs will be combined in order to establish one rate for each service. For each level of service that is paid for on a per unit basis, budgeted costs will be used in determining the initial rates for each. Budgeted costs may include personnel costs (including fringe benefits), operating costs (such as building and equipment maintenance, repairs, depreciation, amortization, and insurance expenses; employee travel and training expenses; utilities; plus material and supply expenses); as well as indirect costs and general and administrative overhead costs. The initial rates will be determined by dividing the budgeted costs by the projected units of service. However, the initial rate for each level of service can not exceed the maximum rate cap established for each level of service. A unit of service for rehabilitative services for Primary Care Enhancement is defined as fifteen (15) minutes of service delivery.

All providers (i.e., private and public) of rehabilitative services for Primary Care Enhancement will be required to submit annual cost reports for each level of service for which they are reimbursed. The cost reports shall include the actual costs of providing each service level as well as service delivery data utilizing the established defined unit of service. These reports will be used to analyze the appropriateness and reasonableness of the reimbursement rates as well as to verify that the Medicaid reimbursement does not exceed the actual allowable costs of providing services. Cost settlements will be performed each year as a result of the submission of the annual cost reports. However, Medicaid reimbursement will be limited to the lower of actual allowable Medicaid costs or the maximum rate cap established for each level of service. The maximum rate cap for each level of service will be established each year using the financial and service delivery data of the largest volume provider of the service. Additionally, future reimbursement rates for providers will be the lesser of the providers actual unit cost or the maximum rate that has been established.

Integrated Personal Care Service - The rate will be calculated utilizing cost report data generated by comparable providers and the data generated by the integrated personal care service providers in their annual cost reports. This per diem reimbursement does not cover room and board services provided to Medicaid recipients. The per diem rate will not exceed the upper limits established through the application of the parameters of 42 CFR 447.304.

17. Nurse Midwife Services:

Self-employed - Reimbursement is calculated at 80% of the current physician allowable amount for the delivery and 100% of the current physician allowable amount.

Employed - Reimbursement is calculated at 100% of the current physician allowable amount.

18. Hospice Services:

With the exception of payment for physicians services reimbursement for hospice services is made at one of four predetermined rates for each day in which an individual is under the care of the hospice. The rate is no lower than the rates used under Part A of Title XVIII Medicare, adjusted to disregard cost offsets attributable to Medicare coinsurance, using the same methodology used under Part A. The four rates are prospective rates. There are no retroactive adjustments other than the limitation on payments for inpatient care. The rate paid for any particular day varies depending on the level of care furnished to the individual.

The four reimbursement rates are applicable to the type and intensity of the services (level of care) furnished to the individual for that day. The four levels of care into which each day of care is classified are:

- Routine Home Care
- Continuous Home Care
- Inpatient Respite Care
- General Inpatient Care

For continuous home care, the amount of payment is determined based on the number of hours of care furnished to the patient on that day.

Limitations on Inpatient Care

Payments to a hospice for inpatient care must be limited according to the number of days of inpatient care furnished to Medicaid patients. The requirements found in 42 CFR 418.302(f)(1)-(5) will be imposed when implementing the limitations on inpatient care.